

00-17437

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) AKA OLIVER BUSTER EDGAR ADKINS			2a. DATE OF DEATH MONTH DAY YEAR September 3, 1986		2b. HOUR 3:30pm	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 16 1916		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md.		12b. CITY OR TOWN Baltimore		12c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Eli Adkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Prater				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 423-18-9023		17. INFORMANT ADDRESS Frances Scalf (sister) same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, acute & organizing, right lower & middle lobes. DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema of lungs, severe. Fibrous pleural adhesions, bilateral, marked. DUE TO, OR AS A CONSEQUENCE OF (c) Splenitis, acute, probable sepsis (neutrophilic leukocytosis) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. TWBC 32,000						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 13 , 19 86 , to September 3 , 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE AVELINA HERNANDEZ, M.D.				22c. DATE SIGNED 9-4-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AVELINA HERNANDEZ, M.D.				22e. ADDRESS VA Medical Center, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/6/86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL HOME OR ADDRESS 9705 Belair Rd. 21236		25a. DATE REC'D. BY REGISTRAR SEP 9 1986		
25b. REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

8625870

70491-00

0-17305

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MEGHAN L ANDRUS			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 1 1986		2b. HOUR M 8:57
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 6 86	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 4	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN CHESAPEAKE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 832 BIDDLE ST			
14. FATHER'S NAME FIRST MIDDLE LAST DONALD V ANDRUS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TENNIFER K. KAISKERN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS DONALD V. ANDRUS CITY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Acute meningitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Charles P. Kokes</u>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 9-2-86	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-4-86		23c. NAME OF CEMETERY OR CREMATORY BETHEL	
23d. LOCATION CITY OR TOWN CHESAPEAKE		COUNTY CECIL		STATE MD	
24. FUNERAL DIRECTOR NAME R.T. FORD FUNERAL HOME		ADDRESS CHESAPEAKE CITY MD		25a. DATE REC'D. BY REGISTRAR SEP 8 1986	
25b. REGISTRAR'S SIGNATURE <u>Charles P. Kokes</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1-1302

CHURCH

CHURCH



1

18153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH ESTIMATED			21. DATE OF DEATH			22. HOUR		
Perry Ellis Barr			X 9 14 1986			9 14 1986			1058 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD			23. HOUR		
Male	White	Sept. 14, 1918	68 YRS.			9 14 1986			1058 PM		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12. MARRIED X NEVER MARRIED WIDOWED DIVORCED			13. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			U.S.A.						Cecil County MD.		
14. CITY OR TOWN OF DEATH			15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			17. KIND OF BUSINESS OR INDUSTRY		
Rising Sun			1 Theresa Avenue			Ballistic Research			APG		
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			19. CITY OR TOWN			20. INSIDE CITY LIMITS?			21. STREET ADDRESS		
Maryland			Cecil			YES NO X			1 Theresa Avenue 21911		
22. FATHER'S NAME			23. MOTHER'S MAIDEN NAME			24. ADDRESS			25. ADDRESS		
Ellis F. Barr			Anna S. Rock			Gloria M. Barr, Rising Sun, Md. 21911					
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			27. SOCIAL SECURITY NO.			28. INFORMANT			29. ADDRESS		
Yes			W.W. II			213-07-1737			Gloria M. Barr, Rising Sun, Md. 21911		
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Carcinoma of lung											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
32. DATE OF OPERATION			33. CONDITION FOR WHICH OPERATION WAS PERFORMED?						34. AUTOPSY?		
									YES NO X		
35. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			36. TIME OF INJURY			37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
38. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK			39. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			40. LOCATION					
						CITY OR TOWN COUNTY STATE					
41. I certify that I took charge of the remains described above, held on Autopsy Inspection X Inquiry and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner											
42. ACTUAL SIGNATURE			43. TITLE (SPECIFY)			44. MEDICAL EXAMINER			45. DATE SIGNED		
Juan C Gonzalez-Vitale, MD			Deputy						9-14-86		
46. EXAMINER'S NAME (TYPE OR PRINT)			47. ADDRESS			48. DATE REC'D. BY REGISTRAR			49. REGISTRAR'S SIGNATURE		
Juan C Gonzalez-Vitale, MD			Union Hospital, Elkton, MD 21921			SEP 16 1986					
50. BURIAL, CREMATION, REMOVAL (SPECIFY)			51. DATE			52. NAME OF CEMETERY OR CREMATORY			53. LOCATION		
Burial			Sept. 18, 1986			Hopewell Cemetery			Port Deposit Cecil Maryland		
54. FUNERAL DIRECTOR			55. DATE REC'D. BY REGISTRAR			56. REGISTRAR'S SIGNATURE			57. REGISTRAR'S SIGNATURE		
Lee A. Patterson & Son, Perryville, Maryland			SEP 16 1986								

18123

Bar Ellis

68

X

Carroll County



W. H. F. H.

RECEIVED

Carroll County

X

8-14-32

Defied

X

X

00-18498

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 8 7 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Roland			2a. DATE OF DEATH MONTH DAY YEAR Sept 11 1986			2b. HOUR 19:45 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Town Government	
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Jane			13e. STREET ADDRESS / ZIP CODE 712 Bridge St., Elkton, Md. 21921			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 03 7359		17. INFORMANT ADDRESS Donald Blansfield, Elkton, Md.					
18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ALTO MYOCARDIAL INFARCTION								1 hour	
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE								Yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a ANEMIA PNEUMONIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/12 19 86 to 9/11 19 86 , that (I) (we) last saw the deceased alive on 9/11 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Linwood Briggs				DEGREE M.D.				22c. DATE SIGNED 9/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linwood Briggs, M.D.				22e. ADDRESS 721 Bridge Street, Elkton, Md. 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/13/86		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chesapeake City, Cecil, Md.			
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals,				ADDRESS Elkton, Md.		25a. DATE REC'D. BY REGISTRAR SEP 19 1986			
25b. REGISTRAR'S SIGNATURE [Signature]									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "None," show any injury, or other traumatic event, or the medical conditions which caused the death.

WMO
80

WMO
80



1

George C. H. Co.

00-20335

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 5 8 7 4

1. DECEASED NAME (TYPE OR PRINT) <u>Rev. Henry Thomas Caldwell</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>September 30, 1986</u>		2b. HOUR <u>6:00 a.m.</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>11 5 1895</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Elkton, Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD.	
10. CITY OR TOWN OF DEATH <u>Elkton</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Minister, Farmer God-Agri.</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Md.</u>		13b. COUNTY <u>Kent</u>	13c. CITY OR TOWN <u>Galena</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>James Lewis Caldwell</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Annie Walter</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW1</u>		17. INFORMANT ADDRESS <u>Isabell Caldwell Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Klebsiella Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypophysectomy and adrenal insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>one week</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute CHF</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the undersigned) attended the deceased from <u>Sept 19 75</u> , to <u>30 Sept 86</u> , 19____, that (I) (we) last saw the deceased alive on <u>30 Sept 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (didn't) view the body after death.					
22b. SIGNATURE <u>Wallace Obenshain, M.D.</u>				22c. DATE SIGNED <u>Oct 1, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wallace Obenshain, M.D.</u>		22e. ADDRESS <u>Cecilton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-2-1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Massey Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Massey Kent Md.</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>Fellows Funeral Home Millington, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>OCT 08 1986</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-18154

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM R. CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR September 10, 1986		2b. HOUR 11:44am
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 29 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Train Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY B&O Railroad
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 88 Simmers Lane 21903	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred L. Campbell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wanda Stebbing		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1945 216-14-4514		17. INFORMANT ADDRESS Darlene M. Jack Perryville, Md. 21903	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cardio vascular disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Hypertension**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 21 , 19 86 , to September 10 , 19 86 xxxxxxxx above, if I (we) did not view the body after death and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE Roy W. Chesnut, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-11-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 14, 1986	23c. NAME OF CEMETERY OR CREMATORY North East Meth. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Maryland
24. FUNERAL HOME Lee A. Patterson & Son Funeral Home, Perryville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 16 1986	

10-18124



NOTED 8/20/50

UNRECORDED

Noted

00-17298

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST MIDDLE LAST LETTIE R. CHAPMAN			MONTH DAY YEAR Sept. 3, 1986			M M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS 90		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD				
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 311 Landing Lane, Apt. 6 21921	
14. FATHER'S NAME FIRST MIDDLE LAST James E. Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Oregon Texas Linamood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213 74 5847		17. INFORMANT ADDRESS Mrs. Mary Ruth Ward, 311 Landing Lane, Elkton, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) gaugreen of bowel

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>72</u> , to <u>9/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jui-Chin Hsu</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chin Hsu				22e. ADDRESS 223 West Main St., Elkton, Md. 21921			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/86		23c. NAME OF CEMETERY OR CREMATORY Rose Bank Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Calvert Cecil Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hicks Home for Funerals, Elkton, Md.				25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please return the other copies of this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2025 EDITION FILE

WITNESS



X

2025 EDITION FILE

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

00-17764

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eugene F. Conley			2a. DATE OF DEATH MONTH DAY YEAR September 6, 1986			2b. HOUR 10:15A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point V.A. Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Center Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Autp	
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Perry Point		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Perry Point V.A. Med. Cen. 21902	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Conley				15. MOTHER'S MAIDEN NAME MIDDLE LAST Blanche Pace					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 162 16 6535		17. INFORMANT Mildred Conley		P.O. ADDRESS Box 4441 Pittsburgh, Pa. 15205	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overwhelming pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that X (this hospital) attended the deceased from December 3, 1985, to September 6, 1986, that X (we) last saw the deceased alive on September 6, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above X (we) (did) not view the body after death.									
22b. SIGNATURE Michael Delahunt M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-6-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL DELAHUNT, M.D.					22e. ADDRESS VA Medical Center, Perry Point, MD 21902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-86		23c. NAME OF CEMETERY OR CREMATORY Quantico Natl			23d. LOCATION COUNTY STATE William Va.		
24. FUNERAL DIRECTOR NAME CROUCH FUNERAL HOME, NORTH EAST, MD 21901					25a. DATE REC'D. BY REGISTRAR SEP 11 1986		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

00-12284

93514 M01703 2007

END

MIA/FA/1/1



00-19461

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Their please return carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 48, there is only injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 6 2 5 8 7 8				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ERNEST W. CRAIG JR.					2a. DATE OF DEATH MONTH DAY YEAR SEPT. 23, 1986			2b. HOUR 12 NOON	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR FEB. 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) EARLEVILLE, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY CECIL 13c. CITY OR TOWN EARLEVILLE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1125 1975 CRISTAL BEACH RD 21919		
14. FATHER'S NAME (TYPE OR PRINT) ERNEST W. CRAIG SR.					15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) MARY WOOLEYHAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 222-01-5288		17. INFORMANT ADDRESS GRACE CRAIG wife same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) (us) attended the deceased from June 1980 19____ to 23 Sept 19____ 86, that (I) (we) (us) lost saw the deceased alive on 23 Sept 19____ 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE Wallace Obenshain M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 24 Sept 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D.					22e. ADDRESS CECIL-KENT HEALTH SERVICES, CECILTON MD 21913				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9/27/86		23c. NAME OF CEMETERY OR CREMATORY JOHNTOWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE EARLEVILLE, CECIL, MD			
24. FUNERAL DIRECTOR FELLOWS F.H. 226 E. MAIN ST. CECILTON, MD 21913					25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE William D. ...		

12401-00

00-18438

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Benjamin C. Everett								9 10 19 86		9		10		19		7:35 PM					
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		White		June 1, 1922		64 YRS.						9 10 19 86		9		10		19		7:35 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Glasgow, Del.		U.S.A.										Cecil County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Elkton		Union Hospital of Cecil Co.		Mechanic-Diesel		Md. Material															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.		Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		71 Nazarene Camp Rd.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Frank		Alice																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
yes		WW 2		212-18-8786		Maxine Barton		71 Nazarene Camp Rd.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
				Atherosclerotic heart disease																	
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
						(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				Chronic obstructive pulmonary disease. Arterial hypertension																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
EXAMINER'S NAME (TYPE OR PRINT)		M.D.		MEDICAL EXAMINER		DATE SIGNED															
Juan C Gonzalez-Vital MD		Deputy		MEDICAL EXAMINER		9-10-86															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Burial		9-13-86		North East Meth. Cem.		North East Cecil Md.															
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Gee Funeral Home, P.A.		SEP 15 1986		Julia Davidson-Randall																	
Elkton, Md.																					

100-18430

100-18430

100-18430

100-18430

100-18430

100-18430

100-18430

100-18430

100-18430

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 8 8 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUGENE P. FORTUGNO			2a. DATE OF DEATH MONTH DAY YEAR September 11, 1986		2b. HOUR 11:55am
3 SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9 29 28		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician	12b. KIND OF BUSINESS OR INDUSTRY T.V. Repair	
13a. STATE Del.		13b. CITY OR TOWN New Castle	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 125 Glenrich Ave. 19804	
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Fortugno		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rose Lamanna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea 222-16-2000	17. INFORMANT ADDRESS Patricia Fortugno (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 6, 1980 to September 11, 1986 xxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Roy W. Chesnut, Jr. MD		DEGREE MD		22c. DATE SIGNED 9-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/16/86		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington New Castle Del.					
24. FUNERAL DIRECTOR NAME George Gonce		4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR SEP 15 1986	
25b. REGISTRAR'S SIGNATURE John Davidson					

NOTICE OF SALE



NOTICE OF SALE
The following is a notice of sale of the property described in the foregoing plat, to-wit: A certain lot or lots of land, situated in the County of [illegible] State of [illegible], containing [illegible] acres, more or less, and being more particularly described in the foregoing plat, as the same appears by the record of said plat in the office of the County Clerk of said County, to-wit: [illegible] of the [illegible] of [illegible] 19[illegible].

And the same is to be sold to the highest bidder for cash, at the Court House of said County, on the [illegible] day of [illegible] 19[illegible], at the hour of [illegible] o'clock of the day.

Witness my hand and the seal of said County, this [illegible] day of [illegible] 19[illegible].

County Clerk of said County.

00-19467

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PHILIP A. FOSTER JR.				2a. DATE OF DEATH MONTH DAY YEAR September 24, 1986		2b. HOUR 11:55am	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 27 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY Sears	
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Conowingo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Philip A. Foster Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara A. Trimble			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-1945		17. INFORMANT Elenora Foster		ADDRESS Same as 13 Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac dysrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Idiopathic hypertrophic cardio myopathy							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 5, 1986 to September 24, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death, so state.)							
22b. SIGNATURE <i>A. Hernandez</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. HERNANDEZ, M.D.				22e. ADDRESS VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-86		23c. NAME OF CEMETERY OR CREMATORY West Nottingham		23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Md.	
24. FUNERAL REC'D. <i>Richard L. Goodie</i>				25a. DATE REC'D. BY REGISTRAR SEP 20 1986		25b. REGISTRAR'S SIGNATURE <i>Richard L. Goodie</i>	

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a discussion of the findings. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a discussion of the findings. The fourth part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a discussion of the findings. The fourth part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a discussion of the findings. The fourth part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a discussion of the findings. The fourth part of the report is a conclusion and a list of references.

00-19468

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 8 8 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy E. Fullerton			2a. DATE OF DEATH MONTH DAY YEAR Sept. 24, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 2 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unice Sumner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Octavia Underwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-18-7976		17. INFORMANT ADDRESS Helen Ayers Same as 13 above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adrenal COPD pneumonia</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension and CVA</u>		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24/86</u> to <u>9/24</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/24/86</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>	DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/26/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui Chih Hsu</u>	22e. ADDRESS <u>223 West Main St. Cecil, Md.</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-27-86	23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist	23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Md.
24. FUNERAL DIRECTOR NAME R.T. Foard		25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE SEP 29 1986	

3 7 0 3 5 8 8

RECEIVED
OFFICE OF THE
DIRECTOR
JAN 11 1968



00-10401-00

Handwritten notes in the center of the page, including the words "Handwritten" and "Handwritten" repeated.



Handwritten notes at the bottom of the page, including the words "Handwritten" and "Handwritten" repeated.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 25883

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Warren Gillespie</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Sept 18 1986</i>		2b HOUR <i>1:05 PM</i>
3 SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Feb 26 1901</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tenn.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.	
10 CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Education</i>	
13a STATE <i>Md.</i>		13b COUNTY <i>Kent</i>	13c CITY OR TOWN <i>Galena</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <i>108 Cross St. 21635</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles P. Gillespie</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fona Bennett</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (UNKNOWN))	16b SOCIAL SECURITY NO. <i>N/A</i>	17 INFORMANT <i>Frances Gillespie</i>		ADDRESS <i>SAME</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial ischemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>ASAD</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Acute Respiratory Failure + Massive Brain stem infarction</i>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the physician) attended the deceased from <i>Sept 9</i> , 19 <i>86</i> , to <i>Sept 18</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>Sept 18</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Wallace Shenbain</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>9-18 86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>9-19-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Silverbroke</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Wilmington City Del.</i>
24 FUNERAL DIRECTOR <i>Fellows Funeral Home</i>		ADDRESS <i>Millington, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 24 1986</i>	
				25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

07081-0

00-18217

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 25884

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James R. Haggerty			2a. DATE OF DEATH MONTH DAY YEAR Sept 10 1986		2b. HOUR 1810 M
3. SEX male	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 16 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) painter	12b. KIND OF BUSINESS OR INDUSTRY Repair	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware			13b. COUNTY New Castle	13c. CITY OR TOWN Newark	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Tonny Haggerty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Reed		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Marines 219 14 0408		17. INFORMANT ADDRESS Katherine L. Harrerty, 15 Laurel Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>7 Sept</u> 19 <u>86</u> , to <u>10 Sept</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10 Sept 86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE Wallace Obenshain MD				22c. DATE SIGNED 10 Sept 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain MD				22e. ADDRESS Cecilton, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/86		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
23d. LOCATION CITY OR TOWN Chesapeake City, Cecil, Md.		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR Hicks Home for Funerals, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

D. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

SEP 18 1986

00-18511

00-18454

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 25885

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES FRANKLIN HARNER			2a. DATE OF DEATH MONTH DAY YEAR September 17, 1986		2b. HOUR 12:15pm		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 05 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
14. FATHER'S NAME FIRST MIDDLE LAST John Harner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Spiker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW1		17. INFORMANT ADDRESS Dana Staples 7104 Sollers Pt. Rd. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia, chronic disease and malnutrition							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that the (this hospital) attended the deceased from April 29 , 19 86 , to September 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (it) did not view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.				22e. ADDRESS VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home, Dundalk, Md.				25a. DATE REC'D. BY REGISTRAR SEP 19 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP

00-18424



0-18152

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Elsie M. Hickman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>September 14, 1986</i>		2b. HOUR M						
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 2, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.					
10. CITY OR TOWN OF DEATH <i>Port Deposit</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>112 Principio Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sewing</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bata Shoe Factory</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>112 Principio Road 21904</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ransom Barrow</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Christy Deaver</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>--</i>		17. INFORMANT ADDRESS <i>Lester E. Hickman, Port Deposit, Maryland.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Old cell carcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>heavy smoker</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>10-15</i> 19 <i>85</i> to <i>9-13</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>9-13</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Neil R. Taylor Jr.</i>				DEGREE <i>M.D.</i>				22c. DATE SIGNED <i>9-15-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Neil R. Taylor Jr. M.D.</i>				22e. ADDRESS <i>Haines Ave. & Walnut, Rising Sun, Maryland.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 17, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cowansing, Cecil Co., Maryland.</i>					
24. FUNERAL DIRECTOR NAME <i>Lee A. Patterson & Son</i>				ADDRESS <i>Perryville, Maryland.</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 16 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Bond</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-192361

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 25887

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Naomi A. James			2a. DATE OF DEATH MONTH DAY YEAR Sept 21 86		2b. HOUR 10:35 ^{am}	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 04 08		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		8. CITIZEN OF WHAT COUNTRY? USA.		
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk typist		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE UNK 00000		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur XXXXXXXXX E. Jewell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXXXXXXX Katherine Gottshalk		16. SOCIAL SECURITY NO. 216-44-9202		
17. INFORMANT ADDRESS Sherry L. James 422 High meadow Rd. Reisterstown MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COBD DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. 3 ⁺ m.		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 A.S.C.V.D. + Senile dementia		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET CITY OR TOWN COUNTY STATE Rising Sun, MD		
22d. I certify that (I) (this hospital) attended the deceased from 6 19 83 to 9-21 19 86, that (I) (we) last saw the deceased alive on 9-20 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
23a. SIGNATURE Neil Taylor J. MD		23b. DEGREE MD		23c. DATE SIGNED 9-22-86		
24a. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor J. MD		24b. ADDRESS Rising Sun, MD		24c. MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/>		
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		25b. DATE 9/24/86		25c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.		
26. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399		26b. ADDRESS Aberdeen, Harford, Maryland		26c. LOCATION CITY OR TOWN COUNTY STATE		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0080

La Roche, J. 0 1 2 3 4

00-19330

00-19330

00-19884

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ROBERT SPENCER JOHNSON			MONTH DAY YEAR September 26, 1986			3:05pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
male	Black	MONTH DAY YEAR 3 6 26	60 YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTH PLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
PA.	USA	Baltimore City OR County of Death						
11. CITY OR TOWN OF DEATH	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY	
Perry Point, Md.	VA Medical Center			disabled				
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	14a. STATE	14b. COUNTY	14c. CITY OR TOWN	14d. INSIDE CITY LIMITS?	14e. STREET ADDRESS / ZIP CODE			
MD.	Harford	Darlington	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3350 Cedar Church Rd 21039				
15. FATHER'S NAME	16. MOTHER'S MAIDEN NAME			17. MOTHER'S ADDRESS				
FIRST MIDDLE LAST Clarence Johnson Sr.	FIRST MIDDLE LAST Esther H. Brown			Darlington Md.				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	19. INFORMANT						
yes	9/44-3/46	Lena M. Johnson 3350 Cedar Church Rd, Md.						
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of the prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 6 19 86 , to September 26 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) see the body after death.								
22b. SIGNATURE <i>Abid Mohiuddin</i>						22c. DATE SIGNED 9-26-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABID MOHIUDDIN, M.D.						22e. ADDRESS VAMC, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			9/30/86		St. James UAME		Darlington Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS						25. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE		
Beard Funeral Home, Havre de Grace, Md.						OCT 03 1986		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 2 should be detached for use at the funeral home permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

48821-00

00-18981

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ADDIE M. PIEPIO KING		2a. DATE OF DEATH MONTH DAY YEAR 9 22 86		2b. HOUR 6:55 AM
3. SEX F	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 2 6 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS - YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.
10. CITY OR TOWN OF DEATH EIKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND	13b. COUNTY CECIL	13c. CITY OR TOWN CHES. CITY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROLAND MORRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE M. WARNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 206-1202984		17. INFORMANT ADDRESS ALFRED KING husband same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Act Gastro Intestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Secondary to Aterio Venous Malformation</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>6/28</u> , 19 <u>86</u> , to <u>9/22</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>9/22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Jayantilal K. Patel MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/22/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K PATEL MD		22e. ADDRESS 123 Singlerly Ave, Eikton MD 21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/26/86	23c. NAME OF CEMETERY OR CREMATORY GRACELAWN MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE WILMINGTON, N.C. DEL.	
24. FUNERAL DIRECTOR NAME FELLOWS F.H. 226 E. MAIN ST. CECILTON, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 24 1986		

BP

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. This allows immediate carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation. It is the responsibility of the funeral director to ensure that the certificate is properly filled out. IMPORTANT: If item 21 is marked as "not at work" shows any injury, or other traumatic event, the medical examiner must be notified.

00-18391

CO. COLONEL LINES

NOV 17 1941

(23)

III

C

00-18829

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THOMAS C. KING			2a. DATE OF DEATH MONTH DAY YEAR September 18, 1986		2b. HOUR 10:15am	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7, 1906		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		6b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. CITY OR TOWN OF DEATH Perry Point, MD.		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
8. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas King		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hunt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. 1923-30		17. INFORMANT V.A.M.C. Records, Perry Point, Maryland.		17. ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Anemia of chronic disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alzheimers dementia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from June 28 , 19 85 , to September 18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Louise S. Sultan		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/18/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUISE SULTAN, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris & Co.		
23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, Chester Co., Pa.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR Lee A. Patterson & Son Funeral Home, Perryville, Md.						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove the body tags. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-18820

White

White

April 2, 1966

30

White

121

X

(Cell)

Unknown

B.C.

Washington

X

1000, 1000, 1000, 1000

Thomas

1000

1000

1000

1923-30

1000

1000, 1000, 1000, 1000



1000, 1000, 1000, 1000

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

I. DECEASED NAME FIRST MIDDLE LAST <i>W. Durnite Kirkley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9/3/86</i>		2b. HOUR MIN. SEC. <i>830 A</i>
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 16 1916</i>	6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>70</i>		7. UNDER 1 YEAR MONTHS DAYS <i>0 0</i>
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>LANDENBERG</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
11. CITY OR TOWN OF DEATH <i>EIKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LABORER</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>AUTOMOBILE</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? <i>PA. CHESTER LANDENBERG YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>			
13e. STREET ADDRESS / ZIP CODE <i>10 Skyline Road 99999</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>William J. Kirkley</i>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Laura Burnite</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO NONE</i>			
16b. SOCIAL SECURITY NO. <i>322-10-2846</i>		17. INFORMANT ADDRESS <i>Beatrice Owens Kirkley</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia with possible</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimer's</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Congestive Heart Failure, Urinary Tract Infection</i>					
19a. DATE OF OPERATION <i>-</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>1/5</i> , 19 <i>80</i> , to <i>3 Sept.</i> , 19 <i>85</i> , that (1) we last saw the deceased alive on <i>2 Sept 8</i> , 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.					
22b. SIGNATURE <i>Charles Hensgen</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3 Sept 85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles Hensgen MD</i>		22e. ADDRESS <i>North East Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9-5-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FAGGS MANOR CEMETERY</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>LOUDBERRY CHESTER Co. PA.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Richard L. Grodie Rising Sun, Md.</i>			
25a. DATE REC'D. BY REGISTRAR <i>SEP 19 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

12
0-48694
6
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the aid of a physician. If the deceased was not attended by a physician, the certificate may be executed by a coroner or a medical examiner.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



00-17297

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25892

I. DECEASED NAME (TYPE OR PRINT)				FIRST				MIDDLE				LAST				2a. DATE KNOWN OF DEATH				2b. HOUR			
Mark				N.				Leathrum								9/ 3/ 19 86				a m			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR							
Male		White		Feb. 27, 1961		25		MONTHS		DAYS		9/ 3/ 1986				9:27 a m							
10. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)				11. CITIZEN OF WHAT COUNTRY?				12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Elkton, Md.				U.S.A.								Cecil County, MD.											
13. CITY OR TOWN OF DEATH				14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				16. KIND OF BUSINESS OR INDUSTRY											
Elkton				Union Hospital of Cecil County				Mechanic				Boating											
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
17a. STATE				17b. CITY OR TOWN				17c. INSIDE CITY LIMITS?				17d. STREET ADDRESS											
Md.				Cecil				Elkton				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 114 Mitchell St. 21921											
18. FATHER'S NAME								19. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
George N. Leathrum								Nancy Heisler															
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				18b. SOCIAL SECURITY NO.				19. INFORMANT				ADDRESS											
No				221-52-1441				Penny A. Leathrum				114 Mitchell St Elkton, Md											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Pulmonary Thromboembolism																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)				21f. LOCATION															
								STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
TITLE (SPECIFY)																							
M.D. Assistant MEDICAL EXAMINER																							
DATE SIGNED 9/4/86																							
ACTUAL SIGNATURE																							
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				9-6-86				North East Meth.				North East Cecil Md.											
24. FUNERAL DIRECTOR'S NAME																							
Erouch Funeral Home North East, Md.																							
25a. DATE REC'D. BY REGISTRAR																							
SEP 8 1986																							
25b. REGISTRAR'S SIGNATURE																							
John Davidson-Randall																							

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

00-11561

50% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.



00-19223

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Eli		MIDDLE Abraham		LAST Levine		2a. DATE OF DEATH		MONTH September 21, 1986		DAY 21		YEAR 1986		2b. HOUR 7:55P		M M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Feb. 26, 1915 DAY 26 YEAR 1915				6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.									
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center																	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY D.C. Police Dept																	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6802 Parkwood Street (20784)											
14. FATHER'S NAME FIRST Morris				MIDDLE Levine				15. MOTHER'S MAIDEN NAME FIRST Fannie				MIDDLE Marmor				LAST Marmor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WWII				16b. SOCIAL SECURITY NO. 578 62 1914				17. INFORMANT Marjorie Levine				ADDRESS Maryland 20784 6802 Parkwood Street; Landover			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic lung cancer</u>	
	DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
-----------------------	---	---	---

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
	21d. INJURY OCCURRED	21e. PLACE OF INJURY
21f. LOCATION		

MEED	216 INJURY OCCURRED		216 PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		216 LOCATION STREET		CITY OR TOWN	COUNTY	STATE
	WHILE AT WORK	<input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							

27a I certify that (X) this hospital attended the deceased from June 9, 1986, to September 21, 1986, that (X) (we) lost
saw the deceased alive on September 21, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (X) (we) did not view the body after death.

77b. SIGNATURE Michael Taylor, MD DEGREE _____ ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 77c. DATE SIGNED 9/24/86

77a PHYSICIAN'S NAME (TYPE OR PRINT)	77e ADDRESS
MICHAEL TAYLOR, M.D.	VA MEDICAL CENTER, Perry Point, MD 21902

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9/24/86	23c. NAME OF CEMETERY OR CREMATORY Quantico National Cem.	23d. LOCATION CITY OR TOWN Quantico, Virginia	COUNTY STATE
---	----------------------	--	---	-----------------

24 FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEM. CHPLS.		75a DATE REC'D. BY REGISTRAR	75b REGISTRAR'S SIGNATURE
NAME	ADDRESS		
1170	Rockville Pk.; Rockville, Md. 20852	SEP 25 1986	<i>[Signature]</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

00-18553

WINTER 1944
COTTON ROPE



00-18309

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20+

29

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY DUHAMELL LOLLER					2a. DATE OF DEATH MONTH DAY YEAR SEPT. 12, 1986			2b. HOUR 4 pm	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR JUNE 25, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) EARLEVILLE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MD STATE HWY ADMINISTRATION		12b. KIND OF BUSINESS OR INDUSTRY 21913	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN CECIL 13c. CITY OR TOWN CECILTON					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8637 AUGUSTINE HERMAN HWY 21913		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM B. LOLLER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA BAILEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT ADDRESS MARIE LOLLER wife same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive myocardial infarction with</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>One year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1985</u> to <u>12 Sept 1986</u> , that (I) (we) last saw the deceased alive on <u>12 Sept 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE <u>Wallace Obenshain MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-14-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLACE OBENSHAIN MD					22e. ADDRESS CECIL-KENT HEALTH SERVICES CECILTON				
23a. BURIAL, CREMATION, REMOVAL (3555)		23b. DATE 9/16/86		23c. NAME OF CEMETERY OR CREMATORY CECILTON ZION		23d. LOCATION CECILTON, CECIL, MD STATE			
24. FUNERAL DIRECTOR FELLOWS F.H. 226 E. MAIN ST. CECILTON, MD					25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE <u>Wanda Pope</u>		

00-18300



0-18665

 Film 6619 item 1
 FOR
 STATE 9/22/86 rja
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM W. M. LONG			2a. DATE OF DEATH MONTH DAY YEAR September 16, 1986			2b. HOUR 12:45pm				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 29, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Williamsport Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.				
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Chemistry		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 4 Bradbury Rd. 21117	
14. FATHER'S NAME FIRST MIDDLE LAST Frank B. Long			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vesta A. Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF KNOWN) 1951-1952 207-03-7985		17. INFORMANT ADDRESS Mr. Hal A. Long Bethelam Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 6, 1986 to September 16, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, _____)										
22a. SIGNATURE Roy W. Chesnut, Jr.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-17-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Cremation			23b. DATE 9/18/86		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS ELINE F.H., 11824 Reisterstown Rd., Reisterstown, Md.						25a. DATE RECD. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all non-essential pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20001-0



00981

00-17376

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RANALD MACDONALD MACDONALD		2a. DATE OF DEATH MONTH DAY YEAR September 4, 1986		2b. HOUR 6:31 A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR August 12, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY US Government
13a. STATE Maryland		13b. COUNTY Pr. George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Macdonald		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Crawford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 127 07 2872		17. INFORMANT Doris Macdonald ADDRESS same as 13e. (VAMC, Perry Point, Maryland)

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory failure**

DUE TO, OR AS A CONSEQUENCE OF **Sepsis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-6- 19 85 , to 9-4- 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-4- 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input checked="" type="checkbox"/> view the body after death.			
22b. SIGNATURE Michael G. Taylor, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9-4-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. TAYLOR, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE SEPT 5, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax, Virginia
24. FUNERAL DIRECTOR Beall Funeral Home, Bowie, Md.		25a. DATE REC'D. BY REGISTRAR SEP 8 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-17376

RECEIVED
JAN 12 1971
AMERICAN OVERSIGHT
WASHINGTON, D.C.
20540
U.S. GOVERNMENT
PRINTING OFFICE
WASHINGTON, D.C.
20540
JAN 12 1971
AMERICAN OVERSIGHT
WASHINGTON, D.C.
20540
U.S. GOVERNMENT
PRINTING OFFICE
WASHINGTON, D.C.
20540



WASHINGTON, D.C. 20540
JAN 12 1971
AMERICAN OVERSIGHT
WASHINGTON, D.C. 20540
U.S. GOVERNMENT
PRINTING OFFICE
WASHINGTON, D.C. 20540

8 6 2 5 8 9 7

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna M. McWilliams			2a. DATE OF DEATH MONTH DAY YEAR 9 8 1986		2b. HOUR 9 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 29 1906	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Conowingo	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 72 Orvis La.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN Conowingo			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 72 Orvis La. 21918	
14. FATHER'S NAME FIRST MIDDLE LAST / Thomas A. McClintock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arabella Currie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -----		16b. SOCIAL SECURITY NO. 219-28-8242	17. INFORMANT ADDRESS Claire Tyson 88 Wyatt La. Colora. Md. 21917		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Gangrene of foot Lr</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetic Mellitus and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertensive ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Mo 20 Yr 20 Yrs
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Peripheral Vascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from MAY 7, 19 49, to 9/8, 19 86, that (I) (we) last saw the deceased alive on 9/6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Dudley Phillips MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/9/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips MD		22e. ADDRESS Washington Md 21074	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-11-86	23c. NAME OF CEMETERY OR CREMATORY West Nottingham	23d. LOCATION CITY OR TOWN COUNTY STATE Colora Cecil Md.
24. FUNERAL DIRECTOR R.I. Foard Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 11 1986	25b. REGISTRAR'S SIGNATURE

00-17766

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, mostly illegible text in the upper section of the document, possibly a header or introductory paragraph.]

[A block of faint, illegible text, likely a body paragraph.]

[Faint, illegible text at the bottom of the page, possibly a signature or footer.]



00-19005

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
John Kay Murphy			MONTH DAY YEAR 9 7 19 86			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
M	W	7 29 1914	72 YRS.	MONTHS DAYS	HOURS MIN.	9 11 19 86 8:45 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
PENNA			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Perryville			376 Broad Street			6280 PER		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			Cecil			Perryville		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
James T. Murphy			Elizabeth Waring			376 Broad St. 21903		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
YES			W11-KORE3			176-07-7542 WM. W. STRANGE MORRISDALE PH.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Ann M. Dixon, M.D.			M.D. Deputy Chief			9/12/86		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn St. Balto. MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			9/22/86			BRANDVIEW		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
WILLIAM T. WILSON			SEP 22 1986			Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

100% cotton

MADE IN U.S.A.



0-20222

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 5 8 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK C. POWELL			2a. DATE OF DEATH MONTH DAY YEAR SEPT 30, 1986			2b. HOUR 7 P. M.				
3 SEX Male		4 RACE W		5. DATE OF BIRTH MO DAY YEAR 8-29-07		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12. USUAL OCCUPATION (GIVE FOR LAST OR WORKING LIFE) Oper. Engineer		13. KIND OF BUSINESS OR INDUSTRY Industroy		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Delaware			15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS / ZIP CODE 7 Holly Square					
14. FATHER'S NAME FIRST MIDDLE LAST Herman Powell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Powell			16. ADDRESS Betty O'Grady - Middletown, Md				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 221-106685							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) acute myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) atherosclerotic coronary artery disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3129 , 19 79 , to 713 , 19 86 , that (I) (we) lost saw the deceased alive on 713 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Kenneth Lewis, MD			DEGREE			22c. DATE SIGNED 10/1/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD			22e. ADDRESS 12 Pennington ST MIDDLETOWN DE 19701							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 4, 1986			23c. NAME OF CEMETERY OR CREMATOR Townsend Cem.			23d. LOCATION (CITY OR TOWN) Townsend A.C. Rd	
24. FUNERAL DIRECTOR Robert C. Hutchison			25. DATE FILED BY REGISTRAR OCT 07 1986			26. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete information has been furnished to the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, please notify injury, or other traumatic event, the medical examiner will be notified and a medical investigation will be conducted.

00-18218

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Murrell Edward Renn				2a. DATE OF DEATH MONTH DAY YEAR 09 14 86				2b. HOUR 706 AM	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	
13a. STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Renn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clemmin May Day					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Betty W. Renn, 16 Norman Allen St., Elkton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) PROLONGED ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) TRANSVERSE MYELITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: TRANSVERSE MYELITIS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]						DEGREE MD		22c. DATE SIGNED 9/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINWOOD BRIDGES MD						22e. ADDRESS Union Hospital of Cecil County, Elkton, MD 21521			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		23d. LOCATION CITY OR TOWN COUNTY STATE Perryman Harford Md.		
24. FUNERAL DIRECTOR NAME Hicks Home for Funerals,						25a. DATE REC'D. BY REGISTRAR SEP 18 1986			
25b. REGISTRAR'S SIGNATURE [Signature]									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 21 shows any injury, or other traumatic event, the medical examiner must be notified of one.

00-19813

RECEIVED

MINUTE

31st 3rd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examination must be held at least once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Leon Richardson			2a. DATE OF DEATH MONTH DAY YEAR 9-10-86		2b. HOUR 17:07^P
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-1-15	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.		
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (PHOT IN SUCH FACILITY, GIVE STREET ADDRESS) Elkton Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN Kingston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 945 Lombard Rd 21911	
14. FATHER'S NAME FIRST MIDDLE LAST Forrest Richardson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Ferguson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 717-07-5426		17. INFORMANT ADDRESS Margaret E. Richardson (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocard infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 9/10 19 86 to 9/10 19 86 , that (I/we) last saw the deceased alive on 9/10 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.					
22b. SIGNATURE Jui Chih Hsu		DEGREE MD		22c. DATE SIGNED 9/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu MD		22e. ADDRESS 223 West main St Elkton Md 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/15/86	23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford Chester Co	
24. FUNERAL DIRECTOR NAME R.T. Ford		ADDRESS Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 22 1986	

19-10-84 10:10 AM

10-1-12

A

10-1-12

10-1-12

10-1-12

00-20343

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James E. Rierson			2a. DATE OF DEATH MONTH DAY YEAR 9 28 1986			2b. HOUR 3 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 15 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Colora		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2212 Liberty Grove Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			
12b. KIND OF BUSINESS OR INDUSTRY Farm									
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN Colora		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Rierson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Walton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-36-8220		17. INFORMANT Myrtle Rierson, Same as 13 Above			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Pulmonary Current</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 9/23</u> , 19 <u>86</u> , to <u>Sept</u> , 19 <u>86</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>9/23</u> , 19 <u>86</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-1-86		23c. NAME OF CEMETERY OR CREMATORY West Nottingham		23d. LOCATION CITY OR TOWN COUNTY STATE Colora Cecil Md.		
24. FUNERAL DIRECTOR NAME R.T. Foard Funeral Home, Rising Sun, Md.					25a. DATE REC'D. BY REGISTRAR OCT 08 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please include this page with the funeral-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-50343

7

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as illegal under any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 25903

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George T. Sartin Sr.			2a. DATE OF DEATH MONTH DAY YEAR 8/16/86		2b. HOUR 3:20 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 14, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Del.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Coca Cola
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Cecil	13c. CITY OR TOWN North East	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin P. Sartin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Boulden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-01-5278		17. INFORMANT ADDRESS 1157 W. Old Phila Rd.	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive intracerebral/intraventricular hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/7/86 to 8/16/86, that (I) (we) last saw the deceased alive on 8/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edgar E. Folk MD.		DEGREE MD.		22c. DATE SIGNED 8/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk MD.		22e. ADDRESS 304 North St., Elkton, MD 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-19-86		23c. NAME OF CEMETERY OR CREMATORY North East Meth.	
23d. LOCATION CITY OR TOWN North East Cecil Md.		23e. LOCATION COUNTY STATE			
24. FUNERAL DIRECTOR John J. Curran		25a. DATE REC'D. BY REGISTRAR AUG 19 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodette	

BP

George V. ...

1900

NOTICE



...

...

...

...

0-17957

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 4

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILTON E. SAUL			2a. DATE OF DEATH MONTH DAY YEAR 9/8/86			2b. HOUR 2020 M				
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR APR 24 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 yrs		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.				
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR LINE OF WORKING LIFE) M.M. Co.		12b. KIND OF BUSINESS OR INDUSTRY Movie		
13. STATE Delaware			13b. COUNTY N.C.		13c. CITY OR TOWN Middletown		13d. STREET ADDRESS * ZIP CODE Bolton Mill Rd 21999			
14. FATHER'S NAME Harvey			15. MOTHER'S MAIDEN NAME Emma Bennett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes - Navy			16b. SOCIAL SECURITY NO. W.U. 11 036122564		17. INFORMANT Marjorie S. Saul-Middletown				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) acquired immune deficiency syndrome DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 4/15 , 19 82 , to 9/8 , 19 86 , that (I) (we) lost saw the deceased alive on 9/8 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Kenneth Lewis, MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 9/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis			22e. ADDRESS M.D. Middlebrook, Del							
23a. BURIAL, CREMATION, REMOVAL Cremation			23b. DATE 9/8/86		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington N.C. Del			
24. FUNERAL DIRECTOR Robert C. Natanson			ADDRESS Middletown		25a. DATE REC'D. BY REGISTRAR SEP 15 1986					
REGISTRAR'S SIGNATURE										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner may be notified at the time of death.

William L. Gault

APR 1 1964

Dear Mr. Gault:
I have your letter of 3/24/64 regarding the
purchase of 100 shares of common stock of
the company. I am sorry that I cannot
purchase the stock for you at this time.
I will be glad to purchase the stock for you
when the time comes.

X

P

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward Andrew Schramko			2a. DATE OF DEATH MONTH DAY YEAR Sept. 26 1986			2b. HOUR 5 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 26 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Manager		12b. KIND OF BUSINESS OR INDUSTRY Exxon Corp.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN Earleville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 77 Snug Harbor Way 21919		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Schramko			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Minnick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) No		17. INFORMANT Elma Schramko		ADDRESS 77 Snug Harbor Way Earleville, Md. 21919			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular tachycardia due to ASHD DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gangrene of rt. second toe- removed surgically									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the body) attended the deceased from 26 Sept 85 19 to 26 Sept 19 86 , that (I) lost saw the deceased alive on 26 Sept 19 86 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) viewed (did) not view the body after death.									
22b. SIGNATURE Wallace Obenshain, MD.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 26 Sept 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D.					22e. ADDRESS Cecilton, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-86		23c. NAME OF CEMETERY OR CREMATORY Glenwood Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Broomall Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS Fellows Funeral Home Millington, Md.					25a. DATE REC'D. BY REGISTRAR OCT 08 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. This permit is valid for 72 hours after death.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THURMAN J. SLAGLE			2a. DATE OF DEATH MONTH DAY YEAR September 7 1986			2b. HOUR 7:55 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2418 Blue Ball Rd., Elkton, Md 21921	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT H. SLAGLE, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NORA E. CANIPE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 244 24 5129		17. INFORMANT ADDRESS Blanche M. Slagle, 2418 Blue Ball Rd., Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) EPIDERMALOID CARCINOMA OF ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 2 Mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MALNUTRITION, SEVERE									
19a. DATE OF OPERATION 9-24-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEEDING JEJUNOSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-25-86 to 9-7-86 that (I) (we) last saw the deceased alive on 9-7-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew P. Friedberg M.D.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-7-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Andrew P. Friedberg M.D.				22e. ADDRESS 502 Lewis St., Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/86		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.			
24. FUNERAL DIRECTOR Hicks Home for Funerals ADDRESS Elkton, Md.				25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury or other traumatic event, the medical examiner must be notified of case.

General

General

✓



General

General

General

General

General

General

General

General

General

General

General

General

General

0-18727

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RAWDEN Brian SLATER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18 1986		2b. HOUR 2:40A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Enlisted Army		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 410 Roberts Way/21001	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Slater		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Howarth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Mildred E. Slater; Same As Above		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER METASTATIC DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7 24 , 19 86 , to 9 18 , 19 86 , that (I) (we) last saw the deceased alive on 9 18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael A. Taylor</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. TAYLOR				22e. ADDRESS VA MEDICAL CENTER PERRY POINT, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Cremation		23b. DATE 9/18/86		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris and Company		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, Chester, Penna.	
24. FUNERAL DIRECTOR NAME ADDRESS TARRING FUNERAL HOME ABERDEEN MD 21001-3399				25a. DATE RECD. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE	

0018151

UNCLASSIFIED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/00 BY SP-6 [illegible]

00-17307

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 7 0 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRY W. SNYDER			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 2 1986			2b. HOUR 10:05 PM	
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH CALVERT, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT MAJOR NURS. HOME, INC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES MAN		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD.		13b. COUNTY CECIL		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1854 Canowingo Road							
14. FATHER'S NAME FIRST MIDDLE LAST HARRY SNYDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa GERHART					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 192-03-4836		17. INFORMATION ADDRESS Dorothy U. SNYDER 1854 Canowingo Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours. 2 hrs. 5 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a-							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-1-86, to 9-2-86, that (I) (we) last saw the deceased alive on 9-2-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neil Taylor MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-02-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD		22e. ADDRESS Rising Sun, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-3-86		23c. NAME OF CEMETERY OR CREMATORY R.A. FUNERALS & Co.		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester PA.	
24. FUNERAL DIRECTOR NAME RT ROAD FUNERAL HOME Rising Sun Md.		25a. DATE RECD. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE Julia...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7

NOV 19 1954

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE C. TAYLOR			2a. DATE OF DEATH MONTH DAY YEAR September 22, 1986			2b. HOUR 11:25am			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 14 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personel Director		12b. KIND OF BUSINESS OR INDUSTRY Bureaus of Standards	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Montgomery		13c. CITY OR TOWN Beallsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19301 Darnestown Rd. 20839			
14. FATHER'S NAME FIRST MIDDLE LAST George C. Taylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Guthrie				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II			
17. SOCIAL SECURITY NO. 577-36-4026		17. INFORMANT ADDRESS Elizabeth C. Taylor 19301 Darnestown Rd. 20839							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 912 IMMEDIATE CAUSE (a) Bronchopneumonia 2nd to questionable aspiration DUE TO, OR AS A CONSEQUENCE OF 2nd to history of organic brain disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ALZHEIMER'S DUE TO, OR AS A CONSEQUENCE OF (c) 2nd to history of organic brain disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 7, 1983 , to September 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE LOUISE SULTAN, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUISE SULTAN, M.D.				22e. ADDRESS VA Medical Center, Perry Point, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/26/86		23c. NAME OF CEMETERY OR CREMATORY Centenary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Madisonville Charlotte Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Baltimore, Md. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR SEP 29 1986			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-12430

REPT MOTION & CO

GOOD WINTER



00-16848

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 1 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Shepard Thomas, Jr. Charles S. Thomas		2a. DATE OF DEATH MONTH DAY YEAR September 1, 1986		2b. HOUR 10:55PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V. A. Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Shepard Thomas, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Clida Compton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-Korea		17. INFORMANT ADDRESS Mrs. Annada Thomas, 418 Liberty Court, Edgewood VAMC, Perry Point, Maryland, 21040	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arteriosclerotic Cardio Vascular Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Chronic obstructive pulmonary disease, Nonketonic coma, Pneumonitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-13 , 19 86 , to 9-1 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-1 , 19 86 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)			
22b. SIGNATURE <i>Glendon Rayson</i>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9-1-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 4, 1986	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington - Arlington - Va.
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, MD. 21009		25a. DATE REC'D. BY REGISTRAR SEP 5 1986	25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shown any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

31881-00

43817 NOTION 1908

WILKINSON



00-20034

STATE OF MARYLAND RELEASED TO W.W. CHAMBERS FUNERAL
DEPARTMENT OF HEALTH AND MENTAL HYGIENE HOME 9/25/86
CERTIFICATE OF DEATH REG. NO. 86-25911

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Matthew Tunney		2a. DATE OF DEATH MONTH DAY YEAR September 23 1986		2b. HOUR 4:00P M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1919	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. S.Sgt.		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.CO.		13c. CITY OR TOWN Temple Hill	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4217 28TH. Ave. /20748			
14. FATHER'S NAME FIRST MIDDLE LAST William - Tunney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine - Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.11 439 09 7524		17. INFORMANT ADDRESS Marjorie D. Tunney (Daughter) 1440 N.St. N.W.#406 Wash.D.C. 20005	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration pneumonia Approximate interval between onset and death 10 minutes 12 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a S/P cerebral vascular accident with dysphagia, naso gastric tube status					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-23-19-86 to 9-23-19-86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-23-19-86 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. LONERGAN, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/25/86		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale P.G. Md.					
24. FUNERAL DIRECTOR W.W.CHAMBERS CO. INC.		25a. DATE REC'D. BY REGISTRAR 517-11TH St. SE. WASH. D.C. 20003		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

00-50034



100% COTTON



20066

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM N WALLS SR			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 23 1986			2b. HOUR 6:20A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 27 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.				
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter		12b. KIND OF BUSINESS OR INDUSTRY Equip. Install. Fire/Water		
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 218 Old Zion Road 21901	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD F. WALLS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MAY HURD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 218 14 4816		17. INFORMANT Mrs. Mary Cannon, Elkton Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C A OF LARYNX

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from JUNE 6 19 86, to SEPTEMBER 23 19 86, that (I) (we) last saw the deceased alive on SEPTEMBER 23 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Paul Siddoway M.D.				DEGREE		22c. DATE SIGNED 9/23/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL SIDDOWAY				22e. ADDRESS VA MEDICAL CENTER PERRY POINT MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/26/86		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park Elkton		23d. LOCATION CITY OR TOWN COUNTY STATE Cecil MD.	
24. FUNERAL DIRECTOR NAME Hicks Funeral Home, Elkton, MD.				25a. DATE RECEIVED BY REGISTRAR OCT 03 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

30000



10/10/10

10/10/10

00-19351

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 5 9 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank E Waszkiewicz			2a. DATE OF DEATH MONTH DAY YEAR Sept 18 1986		2b. HOUR 5:50 pm
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 13 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Owner	12b. KIND OF BUSINESS OR INDUSTRY Retail
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Ches. City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 412 Lock Street 21915
14. FATHER'S NAME FIRST MIDDLE LAST Frank Waszkiewicz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Eshmond			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 160 09 2840	17. INFORMANT ADDRESS Florence Bores, 412 Lock, Ches. City, Md			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Melanoma wide spread metastaticAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**one year**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (did) attended the deceased from Sept 1 , 19 86 , to Sept 18 , 19 86 , that (I) (was) last saw the deceased alive on Sept 18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Wallace Obenshain MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-18-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M. D.		22e. ADDRESS Cecilton, Md. 21913	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/23/86	23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Phila. Mont. Pa.
24. FUNERAL DIRECTOR Name Hicks Home for Funerals Address Elkton, Md.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED MOTION PICTURE

NOV 20 1934

WILLIAM



00-18974

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH F. WHITLOCK			2a. DATE OF DEATH MONTH DAY YEAR SEPT 16 1986			2b. HOUR 9:15A.M.			
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8-21-1927		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Phila. PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) Whitlock Hospital				12a. USUAL OCCUPATION (TYPE OR PRINT) Johnston Central Bakery		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Laurel N.C.		13b. COUNTY Wicomico		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 808 S. Broad St 19709			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas V. Whitlock Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecilia - Carr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE LAST FOUR DIGITS) W.W. 221-14-4357		17. INFORMANT ADDRESS Barbara K. Whitlock-Middleton					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) idiopathic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 8th 1986 , to SEPT 16th 1986 , that (I) (we) lost saw the deceased alive on SEPT 16th 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth Lewis, MD			DEGREE			22c. DATE SIGNED 9/16/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD.			22e. ADDRESS 12 Pennington St, Middletown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY Old Baltimore Cem		23d. LOCATION Warrick-Cecil, Md.		
24. FUNERAL DIRECTOR NAME Robert C. Hutcheon - Middletown, Md.			25a. DATE REC'D. BY REGISTRAR SEP 24 1986			25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-right permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, select any injury, or other traumatic event, the medical examiner must be notified at once.

17231-00